UTAH HEALTH REFORM:
2010 Legislative Update

April 23, 2010

OLRGC
Office of Legislative Research and General Counsel

Health Reform Legislation Enacted in 2010

- Health insurance

HB 20	Amendments to Health Insurance Coverage in State Contracts
HB 25	Health Reform - Administrative Simplification
HB 39	Insurance Related Amendments
HB 52	Health Reform - Uniform Electronic Standards - Insurance Information
HB 294	Health System Reform Amendments
HB 459	Health Amendments
SB 39	Health Insurance Prior Authorization Amendments

Health Reform Legislation Enacted in 2010

- Medicaid/CHIP
  - HB 260 Children's Health Insurance Plan Simplified Renewal
  - HB 397 Medicaid Program Amendments
  - SB 41 Drug Utilization Review Board Amendments
- Medical liability
  - HB 408 Hospital Claims Management
  - HJR 34 Joint Resolution on Hospital Claims Management
  - SB 145 Medical Malpractice Amendments
- Federal reform
  - HCR 8 Concurrent Resolution on Federal Health Care Reform
  - HB 67 Health System Amendments

Utah Health Exchange Amendments

- Expand Exchange participation
- Expand defined contribution arrangement market (DCAM) offerings
- Modify underwriting/rating practices
- Extend risk adjustment
- Modify administration

Utah Health Exchange Amendments

- Expand Exchange participation

  (See graphic that follows)

  – **LARGE GROUP PILOT**

    Allow large groups to participate in the defined contribution arrangement market (DCAM) one year earlier on a pilot basis, beginning January 1, 2011

  – **DEFINED BENEFIT PLANS**

    Allow small groups to purchase defined *benefit* products offered within the DCAM, beginning January 1, 2011

  – **ALL NEW SMALL GROUP PLANS**

    Beginning January 1, 2013, require insurers to post in the Exchange (but not necessarily the DCAM) any small group products accepting new employee groups

Utah Health Exchange Amendments

	UTAH HEALTH EXCHANGE[1]			
	DEFINED CONTRIBUTION ARRANGEMENT MARKET (DCAM)		OTHER	
TRADITIONAL MARKET	Defined ***Contribution*** Products	Defined ***Benefit*** Products	Individual Products	Small Group Products
Commercial Individual Employer-based Small group Large group Self-funded employer-based benefit plans Public programs Medicaid CHIP HIPUtah Medicare VA TRICARE	**Jan 2010** • Small groups *(Limited Launch)* **Jan 2011** • Small groups *(All Allowed)* • Large groups *(Limited Launch)* **Jan 2012** • Large groups *(All Allowed)*	**Jan 2011** • Small groups *(All Allowed)*	**Jan 2010** • Basic benefit plan for each insurer *(Required)* • Any other plans *(Allowed)*	**Jan 2010** • Basic benefit plan for each insurer *(Required)* • Any other plans *(Allowed)* **Jan 2013** • Any plan enrolling new groups *(Required)*
Premium aggregation	Yes	Yes	No	No
Risk adjustment across insurers[2]	Yes	No	No	No
Employee participation limit	Yes	Yes	Yes	Yes
Employer contribution limit	No	Yes	Yes	Yes

[1]2010 legislative actions shown in RED.

[2]Beginning January 1, 2013, small groups outside the DCAM, including those outside the Exchange, are subject to risk adjustment.

Utah Health Exchange Amendments

- Expand DCAM offerings

  (See graphic that follows)

  – **NEW HDHPs**

    In addition to the Basic Benefit plan already offered in the DCAM, require insurers to offer high deductible health plans with moderate and high deductibles.

  – **MOST POPULAR PLANS**

    Require insurers participating in the DCAM to offer in the DCAM their five most commonly selected plans open to new enrollment and meeting certain conditions

  – **MORE LESS-RICH PLANS**

    Allow insurers to offer additional plans that must be actuarially equivalent to or greater than the new medium-level deductible HDHP plan rather than low-level deductible HDHP (the basic benefit plan)

Utah Health Exchange Amendments

	TYPE	DEDUCTIBLE*	OUT OF POCKET MAXIMUM*	
Required	HDHP 1 Basic Benefit Plan (Lowest Deductible)	**1,200–1,450** 2,400–2,650	**1,200–4,350** 2,400–7,950	*(existing, modified)*
Required	HDHP 2 (Medium Deductible)	**2,500** 5,000	**≤5,950** ≤11,900	*(new)*
Required	HDHP 3 (Highest Deductible)	**5,700–5,950** 11,650–11,900	**≤5,950** ≤11,900	*(new)*
Required	Not specified	Actuarial value at least equal to 115% HDHP 1		*(existing)*
Required Required Required Required Required	Plan 1 Plan 2 Plan 3 Plan 4 Plan 5	The five most commonly selected plans open to new group enrollment that include, a provider panel, a deductible, copays, coinsurance, and pharmacy benefits		*(new)*
Optional	Not specified	Actuarial value greater than HDHP 1 (may offer unlimited number of plans)		*(existing)*
Optional	Not specified	Actuarial value greater than or equal to HDHP 2 (may offer unlimited number of plans)		*(new)*

* **One person amounts in BLUE**; two or more persons amounts in LILAC

All amounts are based on 2010 federally qualified HDHP provisions. Some amounts are statutorily specified figures; others are calculated based on statutory requirements. Calculated figures will change from year to year. For HDHP 1, HDHP 2, and HDHP 3, out of pocket maximums must be amounts less than or equal to three times the respective deductible. OOP maximums exclude out-of-network services. HDHP 2, HDHP 3, and Plans 1 through 5 required no later than 1/1/11. HDHP 1, HDHP 2, and HDHP 3 must all be federally qualified HDHP plans.

Utah Health Exchange Amendments

- Modify underwriting/rating practices
  - **PORTABLE RISK FACTOR** If an employer's insurer outside the DCAM is also participating in the DCAM, allow the employer to enter the DCAM for either a defined contribution plan or a defined benefit plan with the same risk factor (or lower) that the employer would have if renewing with the insurer outside the DCAM (the employer is not required to select the same insurer or plan used outside the DCAM)

  - **INDEPENDENT ACTUARY** Require the Utah Defined Contribution Risk Adjuster Board within the Insurance Department to appoint an independent actuary to review the rates, rating factors, and premiums of small and large group plans offered in the Exchange prior to the publication of the rates in the Exchange

  - **UNIFORM UNDERWRITING/RATING** Prohibit a small group insurer in the DCAM from using rating and underwriting practices that differ between plans marketed inside the DCAM and plans marketed outside the DCAM, and require that to be verified by the independent actuary

  - **ALL PAYER DATABASE** Allow limited use of the All Payer Database for risk adjustment within the DCAM

Utah Health Exchange Amendments

- Extend risk adjustment
  - **LARGE GROUPS INSIDE EXCHANGE**
    Risk adjust large group plans in the DCAM when they begin to be offered January 1, 2011

  - **SMALL GROUPS OUTSIDE EXCHANGE**
    Extend risk adjustment beyond small and large groups marketed in the DCAM to also include small group plans marketed outside the DCAM (including small group plans marketed outside the Exchange), beginning January 1, 2013

Utah Health Exchange Amendments

- Modify administration
  - **ONGOING ENROLLMENT**
    Replace annual enrollment with ongoing monthly enrollment for employers in the DCAM

  - **CARRIER ELECTION**
    Prohibit a carrier that chooses to not participate in the DCAM by January 2011 from participating until January 2013

  - **APPOINTED AGENTS FOR DCAM**
    Allow a person to be appointed by the Insurance Department and listed on the Exchange as a producer for the DCAM if the person:
    - makes application to the Insurance Department
    - is an appointed agent with the majority of the carriers that offer a defined contribution arrangement plan in the Exchange
    - has completed a defined contribution arrangement training session approved by the insurance commissioner

Utah Health Exchange Amendments

- Modify administration
  - **ELECTRONIC UNIFORM APPLICATIONS**
    Require an insurer offering a plan in the Exchange to:
    - accept and process from the Exchange electronic uniform applications and uniform waivers using the electronic standards established by the Office of Consumer Health Services
    - if requested, provide an applicant with a copy of the completed application, either electronically or by mail

  - **ADVISORY BOARD**
    Require the Exchange to create an advisory board consisting of two producers, two consumers, two insurers, the Insurance Department, and the Department of Health

  - **INSURER INFORMATION**
    Clarify the information an insurer must submit to the Exchange and the Insurance Department

Amendments Not Limited to Exchange

- Modify rating provisions
- Increase price transparency
- Increase insurer/plan transparency
- Improve insurance administration
- Promote payment and delivery reform
- Improve Medicaid and CHIP
- Modify medical liability laws
- Respond to federal reform
- Reauthorize Health System Reform Task Force

Amendments Not Limited to Exchange

- Modify rating provisions
  (In and out of the Exchange; effective 1/1/11)

	EXISTING	NEW	
	SMALL GROUP AND INDIVIDUAL	**SMALL GROUP**	**INDIVIDUAL**
1. CLASS OF BUSINESS			
A. Creation	• Carrier may establish up to nine classes without approval of the commissioner (classes must meet criteria) • Commissioner may approve additional classes	• Presumption against classes • Five maximum per carrier • Must be approved by commissioner, based on same criteria • None allowed based on whether plan marketed in the Exchange	Same as small group
B. Variation	Index rate for a class of business may not exceed the index rate for any other class by more than 20%	Same	Same

Amendments Not Limited to Exchange

	EXISTING	NEW	
	SMALL GROUP AND INDIVIDUAL	**SMALL GROUP**	**INDIVIDUAL**
2. CASE CHARACTERISTICS	Limited to: • Family composition • Age • Geographic area • Gender • Industry • Group size • Others approved by commissioner	Limited to: • Family composition – Overall ratio of 5:1 or less – Four tiers: ▫ Employee ▫ Employee + spouse ▫ Employee + dependent(s) ▫ Employee + spouse + dependent(s) • Age – Age bands (for each family tier) ▫ <20 ▫ 5-year bands through age 64 ▫ ≥65 – For each band, a standard slope ratio range: ▫ not to exceed 5:1 ▫ not overlapping any other band ▫ determined by commissioner • Geographic area	Limited to: • Family composition • Age • Geographic area • Gender • Others approved by commissioner

Amendments Not Limited to Exchange

	EXISTING	NEW	
	SMALL GROUP AND INDIVIDUAL	**SMALL GROUP**	**INDIVIDUAL**
3. RATING BANDS	• Maximum ±30% variation from index rate for factors other than case characteristics (health status, claims experience, duration of coverage) • A carrier offering small group and individual plans may offer individual rates more than 30% below the index rate (below the base rate)	Same	Same

Amendments Not Limited to Exchange

	EXISTING	NEW	
	SMALL GROUP AND INDIVIDUAL	**SMALL GROUP**	**INDIVIDUAL**
4. ANNUAL INCREASE	Sum of: • % change in new business premium rate or, if no new enrollees, % change in base premium rate • 15% or less for health status, claims experience, or duration of coverage for the class • adjustment for change in coverage or case characteristics (but an adjustment for an industry class may not exceed the adjustment for any other industry class by more than 15%)	Same, except that the limit on adjustment for industry class as a case characteristic (15% difference) no longer applies	Same as small group

Amendments Not Limited to Exchange

- Increase price transparency
  - **ALL PAYER DATABASE REPORTS**
    Direct the Health Data Committee to use the All Payer Database to report on:
    - geographic variations in medical care and costs
    - certain price increases by providers

  - **HEALTH FACILITY CHARGES**
    Require a health care facility to make available to a consumer, upon request, charges for the following:
    - in-patient procedures
    - out-patient procedures
    - the 50 drugs most commonly prescribed in the facility
    - imaging services
    - implants

  - **PROVIDER CHARGES**
    Require a physician, independent practice nurse, dentist, or chiropractor, to make available to a consumer, upon request, charges for the practitioner's 25 most frequently performed:
    - clinic procedures or clinic services
    - out-patient procedures
    - in-patient procedures

Amendments Not Limited to Exchange

- Increase price transparency
  - **DISCOUNTS**
    Require health care facilities and the practitioners listed above to also make available to consumers, upon request, information about discounts for:
    - services not covered by insurance
    - prompt payment

Amendments Not Limited to Exchange

- Increase insurer/plan transparency
  - **COMPARISON MEASURES**

    Require the insurance commissioner to convene a group to develop data that will allow consumers to compare insurers and plans. The data shall "include consideration of":
    - the value and rate of denied claims
    - the quality and efficiency of claims administration of other administrative processes
    - average out of pocket expenses for plan enrollees
    - consumer assessment of each plan or insurer

    Require all insurers to report for all plans the data developed above

Amendments Not Limited to Exchange

- Improve insurance administration
  - **SIMPLIFIED APPLICATIONS**

    Direct the Insurance Department to develop, with the input of insurers, consumers, and others, shortened and simplified uniform application forms for individual, small group, and large group insurance that:
    - is limited, except for cancer and transplants, to 10 years of history
    - includes a uniform waiver of coverage which does not include health status related questions other than pregnancy

    The forms are to be used by Exchange plans beginning October 1, 2010 and other plans beginning January 1, 2011

  - **COORDINATION OF BENEFITS**
    - Provide uniform language for divorce decrees and child support orders related to the coordination of health insurance benefits when a dependent child of the marriage is covered by both parents' health insurance policies
    - Establish a coordination of benefits process for health insurance claims based primarily on national standards
    - Provide uniform educational material for the public regarding the coordination of health insurance benefits
    - Repeal the coordination of the health insurance benefits process that was to take effect July 1, 2010

Amendments Not Limited to Exchange

- Improve insurance administration
  - **UNIFORM ELECTRONIC STANDARDS**
    Amend provisions related to uniform electronic standards for health insurance claims processing, electronic insurance eligibility information, and electronic information regarding the coordination of benefits and establish a voluntary registry of software vendors who comply with electronic standards

  - **BASIC PLAN FLEXIBILITY**
    Change the basic benefit plan deductible from the lowest amount allowed under a federally qualified HDHP (individual: $1,200; family: $2,400) to an amount within $250 of the lowest amount allowed

  - **CONVERSION POLICIES**
    Authorize and specify how an insurer may discontinue a conversion policy that goes beyond Utah NetCare Plan requirements

  - **SPECIAL ENROLLMENT PERIODS**
    Specify that a person is eligible to enroll in an employer group plan within 60 days of:
    - termination of coverage under Medicaid or CHIP, if the termination was due to ineligibility
    - qualifying for employer coverage assistance under Medicaid or CHIP

Amendments Not Limited to Exchange

- Improve insurance administration
  - **PREAUTHORIZATION**
    Require an insurer who requires preauthorization or preapproval to provide an enrollee, upon request, with a statement of preauthorization if the applicable CPT codes have been submitted to the insurer, effective January 1, 2011

  - **EXTENSION OF UTAH MINI-COBRA**
    Allow an insured to extend Utah mini-COBRA coverage beyond 12 months to the period of time the insured is eligible to receive assistance under the American Recovery and Reinvestment Act of 2009, as amended.

Amendments Not Limited to Exchange

- Improve insurance administration
  - **INSURANCE OFFERED BY STATE CONTRACTORS**

    Amend the requirement that contractors with certain state entities offer qualified health insurance to their employees by clarifying:
    - that the application of a waiting period for health insurance may not exceed the first of the month following 90 days of the date of hire
    - that the qualified health insurance coverage must be offered to employees and dependents who work or reside in the state
    - that the qualified health insurance coverage that must be offered is a minimum standard and an employer may offer greater coverage
    - how an employer offering a defined contribution arrangement may comply with state contract requirements.

    Also amend:
    - the definition of qualified health insurance coverage to clarify standards
    - enforcement provisions to provide protections for good faith compliance

Amendments Not Limited to Exchange

- Promote payment and delivery reform
  - **ALL PAYER DATABASE**
    Authorize use of the All Payer Database for payment and delivery reform demonstration projects
  - **FINANCING**
    Direct the Insurance Commissioner and the Office of Consumer Health Services to apply for financial assistance to create and implement payment and delivery reform demonstration projects
  - **MEDICAID MEDICAL HOME**
    Require the Department of Health to determine the feasibility of implementing within existing budget a three-year patient-centered medical home Medicaid demonstration project
  - **MEDICAID HEALTH OPPORTUNITY ACCOUNTS**
    Require the Department of Health to seek federal approval to implement a Medicaid health opportunity accounts demonstration project and implement the project with the approval of the Health and Human Services Appropriations Subcommittee

Amendments Not Limited to Exchange

- Improve Medicaid and CHIP
  - **MEDICAID AUDITS**
    Require that Department of Health internal auditing resources be allocated to Medicaid in the same or greater proportion that state funding for Medicaid bears to state funding for the Department. Audits are to address efficiency, cost recovery, fraud, waste, abuse, and compliance with best practices.
  - **DIRECT CONTRACTING**
    Require the Department of Health to study and report on the feasibility of contracting directly with providers for primary care services
  - **PHARMACY PRIOR APPROVAL**
    Allows the Drug Utilization Review Board to consider cost, in addition to existing considerations, when determining whether a drug should be placed on Medicaid's prior approval program
  - **SIMPLIFIED CHIP RENEWAL**
    Require CHIP, if grant funding is available, to create a simplified renewal process which allows an eligibility worker, if an applicant consents, to confirm the applicant's adjusted gross income with the State Tax Commission

Amendments Not Limited to Exchange

- Modify medical liability laws
  - **NON-ECONOMIC DAMAGES CAP**
    Amend the cap on non-economic damages that may be awarded in a malpractice action to $450,000 and eliminate the annual adjustment for inflation

  - **"I'm Sorry" PROTECTION**
    Amend the Utah Rules of Evidence to provide that: "Statements, expressions, or conduct that express apology, sympathy, commiseration, condolence, compassion, or general sense of benevolence, or describe the sequence of events relating to the unanticipated outcome of medical care or the significance of events or both are not admissible against a health care provider or an employee of a health care provider to prove liability for an injury."

  - **AFFIDAVIT OF MERIT**
    Require an affidavit of merit from a health care professional to proceed with an action if a pre-litigation panel makes a finding of non-meritorious

  - **OSTENSIBLE AGENT PROTECTION**
    Limit the liability of a health care provider, in certain circumstances, for the acts or omissions of an ostensible agent

Amendments Not Limited to Exchange

- Modify medical liability laws
  - **DEMONSTRATION PROJECT**

    Require the Department of Health to establish a two-year demonstration project to facilitate:
    - open and honest dialogue between a health care provider and a patient or the patient's representative regarding unexpected medical outcomes
    - appropriate and timely resolution of medical malpractice claims

Amendments Not Limited to Exchange

- Respond to federal reform
  - **RESOLUTION TO CONGRESS**
    By concurrent resolution of the Legislature and the Governor, urge Congress:
    - to refuse to pass any health care legislation that contains certain provisions
    - to pass health care legislation with specific provisions
    - should it pass health reform legislation that further restricts states, to grandfather certain state laws, regulations, and practices

  - **LEGISLATIVE REVIEW**
    Prohibit state agencies from implementing any provision of federal health care reform unless the agency reports to the Legislature:
    - whether the federal act compels the state to adopt the particular provision
    - the consequences to the state if the state refuses to adopt the provision
    - the impact to citizens of the state if reform efforts are implemented or not implemented

  - **PROHIBITION OF INDIVIDUAL MANDATE**
    Prohibit an individual from being required to obtain or maintain health insurance

Amendments Not Limited to Exchange

- Reauthorize Health System Reform Task Force
  - **STUDIES**
    - Payment and delivery reform
    - Development of the Exchange, particularly the DCAM
    - Transparency
    - Wellness programs and incentives
    - Pre-authorization for procedures
    - Role of PEHP and other associations in the DCAM
    - Public involvement in reform
    - State response to federal reform